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ABSTRACT

An analysis of policy implementation by the Geriatric Education Centers (GEC) program is presented, using a model developed by Sabatier and Mazmanian (1980). A policy by the Bureau of Health Professions to expand education and training efforts in geriatrics and gerontology led to the creation of four GECs in 1983. By 1989, 38 centers had been funded. The purpose of the GEC program was to provide for the development of regional resource and training centers that focused on interdisciplinary training of health professionals in the care of the elderly. Two methods of accomplishing these objectives is to increase faculty competency and to add to or increase content on geriatrics and gerontology in the curriculum of the specific disciplines. Implementation of GEC policy is discussed in terms of: tractability of the problem (e.g., diversity of target group behavior and extent of behavioral change required); availability of the statute to structure implementation (e.g., incorporation of adequate causal theory and unambiguous policy directives); and non-statutory variables affecting implementation (e.g., socioeconomic conditions and technology and attitudes and resources of constituency groups). In this analysis of GEC policy, the components in the statutory and non-statutory categories appear to be interactive rather than distinct entities. Contains 9 references. (SM)

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Geriatric Education Centers: An Analysis of Policy Implementation

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Considerable attention is given to policy analysis; however, examination of the policy implementation process may not be sufficiently addressed. For policy decisions to be carried out successfully, policy implementation must be effective. Edwards (1980) reiterates that even a brilliant policy will fail to achieve its goals if it is poorly implemented. In this paper, the implementation process of the Geriatric Education Centers (GEC) will be analyzed using a model developed by Sabatier and Mazmanian (1980).

Geriatric Education Center Proposal

The Geriatric Education Center program proposal evolved from a background of ineffective policies and fragmented services for the aged person. Estes (1979) addressed the Older American Act as a case study example to illustrate the failure of social policies for the aged in the United States. Organizations such as the Administration on Aging, Health Resources and Services Administration, National Institute on Aging, National Institute of Mental Health, and Veterans Administration had made significant efforts to strengthen education and training in geriatrics and gerontology; however, their accomplishments were not sufficient to meet the current demands (Department of Health and Human Services, 1984).

A report by the Department of Health and Human Services (1984) documented the inadequate number of health professionals to teach health care providers in the care of the elderly. An estimate of only five to twenty-five percent of faculty in the health professions disciplines were adequately prepared. The need for geriatrics in the preparation of health care professionals is crucial with the increases noted in the elderly population.

Census reports indicated substantial increases in the elderly population with each succeeding year. In 1987, it was reported that by the year 2000 almost thirty-five million Americans would be sixty-five years of age and older. This figure would represent an increase from eleven to thirteen percent in elderly persons since 1980. In addition, the fastest growing segment of the population is persons eighty-five years of age and older. The implications of this increase are important as this group has the

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greatest need for health care services (Department of Health and Human Services, 1987).

A policy by the Bureau of Health Professions to expand education and training efforts in geriatrics and gerontology led to the creation of four Geriatric Education Centers in 1983. By 1989, thirty-eight centers had been funded (John Burns School of Medicine, 1989). Many of these centers have already received funding beyond the initial three year grant period and will seek funding for additional years. The purpose of the Geriatric Education Center program was to provide for the development of regional resource and training centers, which focused on interdisciplinary training of health professionals in the care of the aged person. Two methods of accomplishing these objectives were to increase faculty competency and to add or increase content on geriatrics and gerontology in the curriculum of the specific disciplines (Todd, J. & Solon, J., 1986).

Analysis of the Implementation Process

Implementation of the Geriatric Education Centers will be examined by using a conceptual framework developed by Sabatier and Mazmanian (1980). To determine the influence of specific variables on the implementation of the project, personal and phone interviews were conducted with officials from the Bureau of Health Professions; representatives from a regional Geriatric Education Center; a director from an affiliate university Center for Geriatrics and Gerontology in a regional consortium; and the initial evaluator for a regional Geriatric Education Center. Additional information was obtained by analyzing unpublished documents from the Bureau and the Regional Consortium.

In the Sabatier and Mazmanian model, factors affecting the implementation process are divided into three broad categories of independent variables and several stages of dependent variables. The component variables in each of the three categories will be analyzed; however, sufficient data was not collected at this time to warrant a discussion of the stages of implementation.

The Sabatier and Mazmanian Model is depicted in Figure 1. The three broad categories addressed are: 1. the tractability of the problem, 2. the ability of the policy statute to structure the implementation process and 3. the overall effect of political factors.

Figure 1: ANALYSIS OF POLICY IMPLEMENTATION MODEL

TRACTABILITY OF THE PROBLEM

1. Availability of valid technical theory and technology
2. Diversity of target group behavior
3. Target group as a percentage of the population
4. Extent of behavioral change required

ABILITY OF STATUTE TO STRUCTURE IMPLEMENTATION

1. Incorporation of adequate causal theory
2. Unambiguous policy directives
3. Financial resources
4. Hierarchical integration within and among implementating agencies
5. Decision-rules of implementing agencies
6. Recruitment of implementing official
7. Formal access by outsiders

NON-STATUTORY VARIABLES AFFECTING IMPLEMENTATION

1. Socio-economic conditions and technology
2. Media attention of the problem
3. Public support
4. Attitudes and resources of constituency groups
5. Support for souvereigns
6. Commitment and leadership skill of implementing officials

Stage (Dependent Variables) in the Implementation Process

Policy output of implementing agencies → Compliance with policy outputs by target group → Actual impacts of policy outputs → Perceived impacts of policy outputs → Major revision in Statute

(Sabatier and Mazmanian, 1980)

Tractability of the Problem

The tractability of the problem refers to the ease with which solutions can be identified and implemented to address the problem. Four aspects related to the magnitude of the problem of the implementation of the GECs will be examined.

1. Availability of Valid Technical Theory and Technology. A theory was not identified to use in implementing the policy. Although theories of educational and organizational development exist, these theories did not address the scope and nature of the functions of the Geriatric Education Centers.

2. Diversity of Target Group Behavior. Faculty within colleges and universities were identified as the target group. Since the specific purpose was to use a multidisciplinary approach, professionals from a variety of disciplines with diverse educational needs would be involved.

3. Target Group as a Percentage of the Population. More difficulty will be encountered in solving the problem if a larger number of people are involved. The target group of faculty would be relatively small compared to the total number of faculty; therefore, this variable would not be as significant.

4. Extent of Behavioral Change Required. Behavioral change required may encompass an attitudinal change rather than just a mere accretion of facts. A definite protocol for change in behavior was not identified as services provided to the faculty were highly interactive and supported both immediate and long term goals. Evaluation measures instituted were more dependent on the numbers of persons participating in the program, and examples of tangible results sought were presentations and publications.

The implementation of the GECs was an undertaking of considerable magnitude. Of the four criteria discussed, three criteria posed significant problems. In addition, the GECs were attempting to effect change indirectly to another population, the health care worker. The evaluation of the overall success of the project would be long term and difficult to document.

Ability of the Statute to Structure Implementation

1. Incorporation of Adequate Causal Theory. As previously discussed, a theory was not identified for use.

2. Unambiguous Policy Directives. Policy directives were essentially ambiguous and allowed for broad interpretation. Objectives of the 1983-84 program were delineated in the Federal Register Announcement and the Bureau of Health Professions Program Guide (1983). The statement of purpose called for proposed centers to provide such services as:
   a. Conducting faculty training programs to prepare key resource persons in the various health professions schools;
   b. Providing technical assistance in the design and conduct of appropriate inservice and continuing education programs for practicing health professionals;
   c. Serving as a clearinghouse and supplier of information on multidisciplinary geriatric education programs and instructional resources;
   d. Providing other related educational services in support of geriatric training to academic centers, professional associations and state and local health agencies; and
   e. Assisting health professions schools in the selection, installation, implementation and evaluation of appropriate geriatric course materials and curriculum improvements (Department of Health and Human Services, 1983, p.3).

The objectives provided a broad indication of program intent; however, applicants were not given specific guidance on the design of Geriatric Education Centers. Other sections of the program did give greater direction in the shaping of the projects. Nevertheless, in spite of somewhat ambiguous policy directives, the programs that evolved throughout the country interpreted the objectives in similar ways.

3. Financial Resources. The monetary allocation for the entire Geriatric Education Center project seemed adequate; however, benefits to specific universities within the regional centers differed considerably in the amount allocated. Some universities had sufficient resources; whereas, others received only a token amount.

4. Hierarchial Integration Within and Among Implementing Institutions. Coordination from the Bureau of Health Professions to the regions was described as being somewhat "loose". Communication was excellent between the regional agency and the universities and between the universities in the consortium.

5. Decision Rules of Implementing Agencies. From the functions identified in the Program Guide the regional consortium identified ten objectives for implementation of the project. After the objectives were established, little deviation occurred. A timeline was determine for accomplishments for each year of the project.

6. Recruitment of Implementing Officials. The directors hired were well qualified and committed, and the percent of time for involvement in the consortium was identified over a three year period. There has been a major turnover of personnel since the beginning of the project which has not had a significant impact. From each of the participating universities in the consortia core faculty members representing each discipline were designated for participation in the project.

7. Formal Access by Outsiders. Early in the implementation process, the regional agency abandoned the idea of an advisory board because of expense and difficulty in meeting on a regular basis. Advisory boards involving community leaders, health agencies, and professional organizations were retained on the local level.

Overall, the statute itself provided structure, however, flexibility was allowed in the implementation of the policy. Flexibility was essential since the GECs were diverse in location, needs, personnel, and finances. The statutory variables appeared to have a significant impact on implementation since the leadership was strong, and core faculty demonstrated commitment to the project.

Non-statutory Variables Affecting Implementation

1. Socioeconomic Conditions and Technology. As predicted the population of elderly persons has continued to increase, and health professionals have become aware of the need for a more highly prepared practitioner. Funding of the Geriatric Education Centers remains strong for the fourth and fifth year. Technology in health care continues to expand with the evaluation of methods of diagnosis and treatment.

2. Media Attention. There has been little national media attention other than the announcement in the Federal Register. Media attention would focus on activities of the GECs, primarily on the local level.

3. Public Support. Public support is manifested by the increase in the number of funded centers. Political support becomes more apparent over time when tangible results can be seen.

4. Attitudes and Resources of Constituency Groups. Attitudes of faculty become more positive as they become fully aware of the benefits provided by the Geriatric Education Centers. Major benefits were the development of curriculum guides for faculty use in teaching; the opportunity for collaborative inter-disciplinary research; and the participation in inservice education programs. The impact of resources varied from one institution to another; however, economic conditions are reflected in the dwindling resources within colleges and universities. Strategies have been devised to provide Departments and Schools with tangible benefits such as monetary resources directed back to schools in exchange for faculty participation.

5. Support from Sovereigns. Contributions from the Bureau of Health Professions consisted mainly of technical advice and coordinating functions. Sessions are held periodically to assist applicants as they prepare for initial or continuation funding. Workshops at the regional level were held to share ideas an discuss problems with GECs from other areas. In 1986, the first summer institute, which has become an annual event, was sponsored by the regional consortium for development of core faculty and to present research. Although support varied within the institutions, on the local level it was essentially high as most institutions applied for continuation funding.

6. Commitment and Leadership Skills of Implementing Officers. There appeared to be a consensus that the commitment of officials on the regional level was excellent. The regional officials stated that leadership on the university level was one of the crucial factors in the implementation of the programs. Strong leadership overrode negative effects, such as lack of resources.

The non-statutory variables continue to exert considerable influence on the success of the implementation of the GECs; however, short-term evaluation remains difficult since political factors may not have immediate tangible results. Sabatier and Mazmanian (1980) contend that initially the influence of the statute is the most important variable affecting implementation; however, overtime political factors become a paramount

consideration. Browning, Marshall, and Tabb (1980), in analyzing the implementation of federal grants for social programs, found the non-statutory variables were frequently stronger than Sabatier and Mazmanian indicated.

In this analysis of the Geriatric Education Center policy, the components in the statutory and non-statutory categories appear to be interactive rather than distinct entities. For example, if the financial resources were generous, the statutory variables may be more influential. However, if the resources were scarce, a major influence might be the creative management of resources by the center director combined with positive attitudes and commitment of faculty groups. In addition, the influence of outsiders may be more relevant with increased media attention an public support.

The Sabatier and Mazmanian Model has versatility in that it has been utilized to analyze micro, macro, distributory, and regulatory policy. The framework is particularly helpful in examining specific variables that may impact on the implementation of the policy statutes. Further study of the implementation of the Geriatric Education Centers would be helpful in determining the influence of the specific variables over time. A focus on the stages of the implementation process, the dependent variables as identified by Sabatier and Mazmanian, would yield information essential to decisions that may result in the revision of the statute itself.

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